

RETROACTIVE MEDICAID APPLICATION

State of Michigan Family Independence Agency

AUTHORITY: Federal 42 CFR 435. **COMPLETION:** Voluntary.

PENALTY: No medical coverage will be authorized.

The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA Office in your county.

Grantee Name				Grantee Client ID	
Case Number				Date	
County	District	Section	Unit	Specialist	Other ID (as required)

1. My family has unpaid medical bills for the month(s) of:

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
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▼ ANSWER QUESTIONS 2-9 FOR EACH MONTH APPLIED FOR IN QUESTION 1. ▼

2. List yourself and the name of each family member who lived with you at any time during the first month . Check yes if the person has unpaid medical expenses this month.	2. List yourself and the name of each family member who lived with you at any time during the second month . Check yes if the person has unpaid medical expenses this month.	2. List yourself and the name of each family member who lived with you at any time during the third month . Check yes if the person has unpaid medical expenses this month.
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the first month ? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, enter name of family member(s):	3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the second month ? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, enter name of family member(s):	3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the third month ? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, enter name of family member(s):
4. Explain any changes during the first month (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change.	4. Explain any changes during the second month (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change.	4. Explain any changes during the third month (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change.

INCOME: (Questions 5-7) For each month applied for, attach proof of all income received. Attach copy of court order(s) for child support paid.

5. Was any family member employed or self-employed in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete the following:	FIRST MONTH		SECOND MONTH		THIRD MONTH	
	Total monthly earned income before deductions	Names of children receiving child care due to employment.	Total monthly earned income before deductions	Names of children receiving child care due to employment.	Total monthly earned income before deductions	Names of children receiving child care due to employment.
Person employed:	\$		\$		\$	
	\$		\$		\$	
Name of Self-Employed Person	Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)		Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)		Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)	
6. Did any family member pay child support in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete the following:	Total monthly child support paid	Total monthly child support paid	Total monthly child support paid	Total monthly child support paid	Total monthly child support paid	Total monthly child support paid
Person paying expenses:	\$	\$	\$	\$	\$	\$
7. Did any family member pay guardianship/ conservator expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?	7. Did any family member pay guardianship/ conservator expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?		7. Did any family member pay guardianship/ conservator expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?		7. Did any family member pay guardianship/ conservator expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?	

8. OTHER INCOME: Include income of all family members. Each item must be answered YES or NO.									
	FIRST MONTH			SECOND MONTH			THIRD MONTH		
	Month	Year		Month	Year		Month	Year	
INCOME TYPE	YES/NO	MONTHLY AMOUNT	WHOSE INCOME	YES/NO	MONTHLY AMOUNT	WHOSE INCOME	YES/NO	MONTHLY AMOUNT	WHOSE INCOME
Social Security Benefits (RSDI)		\$			\$			\$	
Supplemental Security Income (SSI)		\$			\$			\$	
Retirement or Pension Benefits		\$			\$			\$	
Veterans Benefits		\$			\$			\$	
Disability Benefits		\$			\$			\$	
Rental Income		\$			\$			\$	
Workers Compensation		\$			\$			\$	
Child Support or Alimony		\$			\$			\$	
Unemployment compensation		\$			\$			\$	
Military Allotments		\$			\$			\$	
Gambling Distributions (Casino profit sharing)		\$			\$			\$	
Other		\$			\$			\$	

9. ASSETS: Include assets of all family members. Each item must be answered YES or NO. Attach proof of asset value for each retro month applied for.									
	FIRST MONTH			SECOND MONTH			THIRD MONTH		
	Month	Year		Month	Year		Month	Year	
ASSET TYPE	YES/NO	AMOUNT/VALUE	OWNER(S)	YES/NO	AMOUNT/VALUE	OWNER(S)	YES/NO	AMOUNT/VALUE	OWNER(S)
Cash on hand, in a safety deposit box or patient trust fund		\$			\$			\$	
Savings, Checking or Credit Union Accounts		\$			\$			\$	
Home, life estate, life lease		\$			\$			\$	
Real Estate (not your home)		\$			\$			\$	
Mortgage, land contract or other notes payable to household member		\$			\$			\$	
Savings bonds or money market funds		\$			\$			\$	
Stocks or mutual funds		\$			\$			\$	
IRA, KEOGH, 401K or deferred compensation accounts		\$			\$			\$	
Trust Fund(s)		\$			\$			\$	
Life insurance		\$			\$			\$	
Annuity		\$			\$			\$	
Cars, trucks, boats, motorcycles, other vehicles		\$			\$			\$	
Tools & Equipment, Livestock or Crops		\$			\$			\$	
Funeral contracts		\$			\$			\$	
Burial plot(s), casket, etc.		\$			\$			\$	
Ce4rtificates of Deposit (C.D.) or savings certificates		\$			\$			\$	
Other		\$			\$			\$	

I CERTIFY THAT ALL INFORMATION I HAVE WRITTEN ON THIS FORM IS TRUED TO THE BEST OF MY KNOWLEDGE.

Signature	Date	Signature of Spouse	Date
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